



#12 Appellants Brief  
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IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

Applicant(s): Lintel III et al

Group Art Unit: 3626

Application No.: 09/496,783

Examiner: Kapadia, Milan

Filed: February 3, 2000

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Title: Healthcare Information Network

Lee Lintel

Attorney Docket No.: ZANS.10001NP

Name

11/4/2003

Date

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P.O. Box 1450  
Alexandria, VA 22313-1450

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APPELLANTS' BRIEF

Dear Sir:

Appellants respectfully present their brief in support of their appeal of the final rejection of claims in this case. The Notice of Appeal was filed on August 4, 2003.

**I. REAL PARTY IN INTEREST**

The real party in interest in this application is Zansor, Inc.

**II. RELATED APPEALS AND INTERFERENCES**

The undersigned is not aware of any appeals or interferences that will directly affect or have a bearing on, or be directly affected by, the Board's decision in this appeal.

### **III. STATUS OF THE CLAIMS**

Claims 17-19 and 21-24 were finally rejected in the Office Action of April 3, 2003 and are the subject of the present appeal.

### **IV. STATUS OF AMENDMENTS**

A final rejection of the claims was issued on April 3, 2003. No amendments were filed in response to the final rejection.

The claims on appeal are presented in the Appendix to Appellants' Brief.

### **V. SUMMARY OF THE INVENTION**

The present invention involves a healthcare information system, including a plurality of healthcare provider office systems. Each provider office system generates referral requests with reference to a database associating insurance healthplans with doctors. The referral requests are received by referral authorization circuitry, which generates electronic authorization requests to associated insurance companies responsive to the referral requests. Pursuant to each of the referral requests, the referral authorization circuitry receives an electronic authorization or denial. Denied requests are forwarded to a third party human researcher for further research; the database is updated responsive to the research.

The present invention provides significant improvements over the prior art. In the field of managed healthcare, primary healthcare providers are responsible for referring a patient to a specialist. The referral must be made to a selected group of physicians approved by a patient's healthcare plan. Thus, a staff member (typically a nurse) must determine which specialists are available to a patient, based on information provided by the various insurance companies. After a specialist is chosen, a request is submitted to the patient's insurance company. Because the information from the insurance companies is often out-of-date, the requests are often denied, restarting the process. Patient referrals are a significant expense to healthcare providers.<sup>1</sup> The present invention allows the referral information available to healthcare providers to improve as the system is used. When a referral request is denied, the cause for denial is researched and the database is corrected, allowing all healthcare providers to share in the updated information.

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<sup>1</sup> Specification, page 4, line 21 through page 7, line 3.

## **VI. ISSUES**

Are claims 17-19 and 21-24 novel and unobvious over the U.S. Pat. No. 5,890,129 to Spurgeon et al in view of U.S. Pat. No. 6,343,271 to Peterson et al?

## **VII. GROUPING OF THE CLAIMS**

Claims 17-19 and 21-24 stand or fall together.

## **VIII. ARGUMENT**

### **A. The rejection**

The Examiner has rejected claims 17-19 and 21-24 under 35 U.S.C. § 103(a) as being unpatentable over U.S. Pat. No. 5,890,129 to Spurgeon et al in view of U.S. Pat. No. 6,343,271 to Peterson et al.

Regarding claim 17, the Examiner contends that Spurgeon teaches a healthcare information system which includes all elements of the claim other than the element of forwarding denied authorization requests to a third party human researcher for further research. Specifically, the Examiner states that Spurgeon shows:

plurality of provider office systems (Spurgeon; abstract and figure 1), each provider office system comprising:

    circuitry for generating referral requests with reference to a database associating insurance health plans with doctors (Spurgeon; abstract, col. 6, lines 24-41, Col. 8, lines 17-21);

    referral authorization circuitry for:

        receiving referral requests (Spurgeon; abstract),

        generating electronic authorization requests to an associated insurance company responsive to ones of said referral requests (Spurgeon; abstract),

        receiving an electronic authorizations/denial for each electronic authorization request (Spurgeon; abstract),

updating said database responsive to said research  
(Spurgeon; Col. 7, line 45-col. 8, line 16 and col. 11, lines 1-11).<sup>2</sup>

With regard to the element of forwarding denied authorization requests, the Examiner contends that Peterson shows this element at column 12, lines 23-64.<sup>3</sup> In response to Applicant's argument that the combination of the Peterson reference and the Spurgeon reference does not show a system where a referral request denial cause an update of the database, the Examiner cites the Spurgeon reference for showing that "Push technology is used to transmit information between the information-exchange computer and the provider interface computer and also teaches updating the associated databases," citing Spurgeon at column 7, line 45 through column 8, line 16.<sup>4</sup>

With regard to claim 18, Examiner states that while Spurgeon fails to expressly disclose referral authorization circuitry that "forwards referral requests that cannot be authorized electronically to a third party human researcher", this element is shown in Peterson's teachings (Peterson; col. 10, line 50 through col. 11, line 76).<sup>5</sup>

With regard to claim 19, the Examiner contends that Spurgeon teaches a central information system having a global database of referral information in communication with said provider office systems (Spurgeon; col. 7, lines 8-27; the examiner interprets the "information-exchange system" as a "central information system.").<sup>6</sup>

With regard to claim 21, the Examiner contends that Spurgeon teaches a system wherein said authorization requests are EDI messages (Spurgeon; col. 7, lines 8-27; the examiner interprets reformatting of data to be compatible with insurer or provider as a form of electronic interchange).<sup>7</sup>

Method claims 22-24 are rejected on a rationale similar to that described in connection with Claims 17 and 18.

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<sup>2</sup> Office Action of 4/3/2003, page 3.

<sup>3</sup> Office Action of 4/3/2003, page 2.

<sup>4</sup> Office Action of 4/3/2003, pages 6-7.

<sup>5</sup> Office Action of 4/3/2003, page 4.

<sup>6</sup> Office Action of 4/3/2003, page 4.

<sup>7</sup> Office Action of 4/3/2003, page 4.

## B. Appellant's Argument

Applicant submits that claims 17-19 and 21-24 are novel and unobvious over the combination of Spurgeon and Peterson. Specifically, Applicant asserts that the Spurgeon and Peterson references, in combination, do not teach a healthcare information system where electronic authorization requests for referrals are submitted to an insurance company and the following actions occur:

- 1) if the authorization request is denied, the authorization request is forwarded to a human for research and
- 2) the database is updated in accordance with the research.

The Spurgeon reference provides a system which correlates information in a health provider database with information in an insurance company database through an information exchange computer using push technology that automatically broadcasts the data to the health provider's database without further human intervention. The push technology keeps the health provider's database in sync with the insurance company's database, using an information-exchange computer as an intermediary.<sup>8</sup> The push technology ensures that data on the provider interface computer is always kept up-to-date with the insurance company database; data from the insurance company database is pushed out to the provider interface computer and into a provider database located therein rather than requiring the provider to pull the data down from the information-exchange computer.<sup>9</sup>

Accordingly, the health provider database contains the same information as the insurance company database. In practice, however, even if an insurance company would provide open access to its information, which is not common, insurance company information *is often not timely and the errors in the insurance company database can be the cause for denials to referral requests*. Reducing the costs inflicted on healthcare providers due to incorrect and untimely information from insurance companies was the impetus for the present invention.<sup>10</sup> In Spurgeon, a denial is simply passed to the healthcare provider.<sup>11</sup> Spurgeon provides no methodology for resolving errors in the

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<sup>8</sup> Spurgeon, column 6, lines 42-60.

<sup>9</sup> Spurgeon, column 7, line 66 through column 8, line 4.

<sup>10</sup> Specification, page 8, lines 1-2.

<sup>11</sup> Spurgeon, column 10, line 65 through column 11, line 10.

insurance company's database. The passage cited by the Examiner to show resolution of errors in the database<sup>12</sup> only shows that the information in the provider database is kept consistent with the information in the insurer's database – it shows no capability of updating information that is incorrect or out-of-date. In fact, the use of push technology teaches away from the present invention – a healthcare provider using the Spurgeon system is forced to use the insurance company data that is pushed to the healthcare provider's terminals.

Hence, Spurgeon does not teach a healthcare information system with referral authorization circuitry for (1) forwarding denied authorization requests to a third party human researcher for further research or (2) updating said database responsive to said research.

These deficiencies are not resolved by adding the Peterson reference. Peterson is directed towards a claims processing system. An automated adjudication system allows health care providers to electronically prepare and submit claims for payment. *Before a claim is submitted*, a claims pre-check process is used to determine whether the claim may be automatically adjudicated or instead must be manually adjudicated system<sup>13</sup>. The choice between automatic adjudication and manual adjudication by a claim shop is made in Peterson in accordance with a pre-checking process at the healthcare providers site<sup>14</sup> or, if not pre-checked at the healthcare provider's site, by the payment system.<sup>15</sup>

The decision to pursue manual adjudication or automatic adjudication in Peterson is performed *prior to submission of the claim* (based on information *provided by the insurance company*), not upon *denial of the claim* by the insurance company, as specified in claim 17. A manual adjudication required by the pre-checking process in Peterson does not suggest that there is anything wrong with the information in the claim. The pre-checking process only identifies claims of a type that the insurance company does not want to automatically adjudicate.<sup>16</sup> There is nothing in Peterson to suggest that a denial of a claim may be the result of an error in the insurance company's database, that manual

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<sup>12</sup> Spurgeon, col. 7, line 45-col. 8, line 16 and col. 11, lines 1-11

<sup>13</sup> Peterson, column 10, lines 50-63.

<sup>14</sup> Peterson, column 10, line 62 through col. 13, line 13.

<sup>15</sup> Peterson, column 13, lines 23-38.

<sup>16</sup> Peterson, column 10, lines 62-65

adjudication can resolve the error, or that the error in the database will be updated upon resolving the error, so that the error will not continually repeat itself. Therefore, combining these two references would not teach the invention to one skilled in the art.

Updating the database is an important aspect of the invention, since an error-free database minimizes the number of referrals that must be processed manually. Minimizing the number of referrals that must be processed manually provides two advantages: (1) valid referrals are processed more quickly and (2) the generation of invalid referrals due to errors in the database, are minimized, because the error is corrected after the human research into the reason for denial. Further, denied referrals generally require additional work by the healthcare provider and the patient in order to obtain an appointment with a new referral physician. By having a dynamically corrected up-to-date database, rather than periodically updated databases supplied by the insurance companies, the number of denied referrals is significantly decreased.

For reasons stated above, Applicants respectfully request allowance of claim 17. Since claim 22 includes the steps of (1) forwarding denied requests to a third party human researcher for further research and (2) updating said database responsive to said research, Applicants request allowance of this claim for reasons stated above in connection with claim 17. Since claims 18, 19 and 21 are dependent upon claim 17 and claims 23 and 24 are dependent upon claim 22, Applicants request allowance of these claims as well.

## **IX. CONCLUSION**

For the foregoing reasons, Appellants submit that all of the claims on appeal in this case are both novel and non-obvious over the prior art of record in this case. Appellants therefore respectfully submit that the final rejection of claims 17-19 and 21-24 is in error. Reversal of the final rejection of the claims in this case is therefore respectfully requested.

Respectfully Submitted,

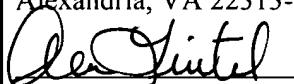


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Filed: February 3, 2000	I hereby certify that this correspondence is being deposited with the United States Postal Service as first class mail in an envelope addressed to
Title: Healthcare Information Network	Commissioner for Patents, P.O. Box 1450,
Attorney Docket No.: ZANS.10001NP	Alexandria, VA 22313-1450 on <u>11/4/2003</u> .
	 Name <u>Alex Lintel</u> Date <u>11/4/2003</u>

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P.O. Box 1450

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**APPENDIX TO APPELLANT'S BRIEF**

Dear Sir:

Appellants respectfully present the claims on appeal in this case:

17. A healthcare information system, comprising:  
a plurality of provider office systems, each provider office system comprising circuitry for generating referral requests with reference to a database associating insurance healthplans with doctors;  
referral authorization circuitry for:  
receiving said referral requests,  
generating electronic authorization requests to an associated insurance

company responsive to ones of said referral requests,  
receiving an electronic authorizations/denial for each electronic  
authorization request;  
forwarding denied authorization requests to a third party human  
researcher for further research; and  
updating said database responsive to said research.

18. The healthcare information system of claim 17 wherein said referral  
authorization circuitry further forwards referral requests that cannot be authorized  
electronically to a third party human researcher.

19. The healthcare information system of claim 17 wherein said database  
comprises a central information system having a global database of referral information  
in communication with said provider office systems.

21. The healthcare information system of claim 17 wherein said authorization  
requests are EDI (electronic data interchange) messages.

22. A method of providing referral information, comprising the steps of:  
providing a database associating insurance healthplans with doctors;  
electronically receiving said referral requests generated by reference to said  
database from a plurality of provider office systems;  
generating electronic authorization requests to an associated insurance company  
responsive to ones of said referral requests;  
receiving an electronic authorization or denial in response to each electronic  
authorization request;  
forwarding denied requests to a third party human researcher for further  
research; and  
updating said database responsive to said research.

23. The method of claim 22 and further comprising the step of manually researching denied authorization requests.

24. The method of claim 23 and further comprising the step of manually researching referral requests that cannot be authorized electronically.

Respectfully Submitted,



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